Confirmation of Receipt of Physician's Statement of Gender Change

State Form 56713 (5-19)
Indiana State Department of Health

SECTION A – APPLICANT'S INFORMATION			
Legal Name *(last, first, middle initial)*			Date of Birth *(mm/dd/yyyy)*
Address *(number and street)*	City		State
ZIP Code	State of Birth	Physician's Name	

Gender Transition from:

☐ Male to Female ☐ Female to Male ☐ Male to X (non-binary) ☐ Female to X (non-binary)

SECTION B – REGISTRAR'S STATEMENT AND SIGNATURE

This form serves as confirmation that the Indiana State Department of Health (ISDH) has received a fully and properly executed *State Form 56712, Physician's Statement of Gender Change*, regarding the above-named Applicant. This form reflects the statement of the above-named Physician that Applicant has received appropriate clinical treatment for gender transition as indicated above in Section A.

This form is sufficient documentary evidence of a gender change for all Indiana state agencies. Please note that federal agencies, local government agencies, and municipalities may not deem this letter as sufficient to document a gender change, and you must follow the relevant policies of those agencies if you desire to change your gender with those agencies.

Signed:_____ Date (mm/dd/yyyy):_____
State Registrar, Director of Vital Records

Printed Name:_____